CALIFORNIA OFFICE OF SUICIDE PREVENTION eNEWS

Every Californian is Part of the Solution... *How will you contribute?*

VOLUME 2
ISSUE 5

MAY 2011

SUICIDE PREVENTION IN EMERGENCY DEPARTMENTS (EDS)

It is estimated that for every 1 suicide in young people, there are 100-200 suicide attempts; in the elderly, the ratio is 1 to 4. Many individuals who attempt suicide are seen in EDs. For this and many other reasons, EDs are quickly becoming the *de facto* option for urgent and acute care for suicidal patients within the healthcare system. This edition of the eNews will discuss the research behind suicide prevention in EDs and resources to help implement ED-based interventions in local hospitals.

DO YOU RECEIVE THE eNEWS?

If so, the Office of Suicide Prevention is interested in hearing from you! The Office wants to tailor the eNews to best suit your needs. Please take a few minutes to answer this Hconfidential surveyH. If you have any questions, please contact HThe Office of Suicide PreventionH.

WHAT WE KNOW ABOUT SUICIDE PREVENTION IN EMERGENCY DEPARTMENTS (EDS)

According to the Suicide Prevention Resource Center (SPRC), nearly 10% of all individuals who are seen in the ED are thinking about suicide. A study by Larkin, et al. (2008) analyzed trends in U.S. ED visits for suicide attempts in 1992-2001. According to this study, individuals ages 15-29 years had the highest suicide attempt rates. Women had significantly higher visit rates for suicide attempts than men while general mental health related visits increased for both men and women over the decade. While it is known that Whites have the highest rates of completed suicides, Blacks had the highest rate of suicide attempt-related ED visits. Also in contrast to characteristics of completed suicides, suicide attempt-related ED visits were higher in urban areas compared to rural areas. Overall, the estimated rate of suicide attempt-related visits increased over the course of the decade, from 2.5 to 4.2 per 1000 ED visits.

In 2009, the California Department of Public Health's EPICenter identified 27,866 ED cases that were attributed to self injury. In addition, 16,356 patients were hospitalized due to the severity of their conditions. These numbers suggest that EDs are an important point of intervention for people who may be at higher risk of suicide.

ED SUICIDE PREVENTION: A FOCUS ON YOUTH

The Larkin (2008) study demonstrated that across the country, youth ages 15-29 years old presenting in the EDs had the highest suicide attempt rates compared to other age groups. This is reflected in California data (2009): 15-24 year olds have the highest numbers of ED visits related to suicide attempts compared to other age groups. The Youth Risk Behavior Survey showed that 8.4% high school students reported an attempted suicide in the past year, while nearly 17% of high school students reported seriously considering an attempt. Additionally, a study by King et al. (2009) showed that more adolescent women than adolescent men are presenting at EDs for suicidal behavior.

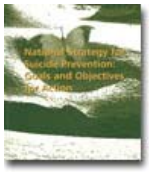
A suicide attempt is a risk factor for future risk of suicide (California Strategic Plan on Suicide Prevention, 2008). Unfortunately, many youth are not in treatment with a mental health professional at the time of their suicide attempt (King, 2009). This is more pronounced in adolescent males than in females. Since nearly 40% of all individuals who die by suicide had been to an ED one year prior to their death (King, et al., 2009), EDs present an opportunity to screen for suicidal thoughts and refer to appropriate resources.

CHALLENGES IN ED SUICIDE PREVENTION

The overall number of ED visits has risen over the years, placing pressure on ED staff to treat more patients with less time. According to Knesper et al. (2010), and Larkin et al. (2010), ED staff may not be adequately prepared to handle suicide attempt cases. In one study, as reported by Knesper et al., a majority of ED patients who reported to researchers of their passive suicidal ideation or plans to kill themselves were not identified as such by their ED physicians. Lack of awareness or education on suicide and attempts can lead to stigmatizing behavior by ED staff. One study by Cerel et al. (2006) showed that consumers and family members seen in the ED after a suicide attempt felt punished or stigmatized by ED staff.

There are also other reasons for why screening and assessing for suicide risk is difficult in ED settings. According to Knesper et al., resistance to conducting ED-based screenings includes the perceived complexity of screening and referrals and the lack of research studies on the feasibility and effectiveness of screenings and referrals. There is also little evidence to suggest that the *current practice* of ED screenings and referrals are effective; it is estimated that up to 60% patients do not follow up with their referrals within a week of being seen in the ED.

ED SUICIDE PREVENTION: A CALL TO ACTION



The National Strategy for Suicide Prevention underscores the need for the development and promotion of ED-based clinical and professional practices to heighten awareness of the presence and/or absence of risk and protective factors associated with suicide. The California Strategic Plan on Suicide Prevention echoes this need in Strategic Direction 2, where ED staff are identified as a group that could benefit from training and workforce enhancements to prevent suicide.

Following these strategic plans, future ED-based interventions and research should focus on suicide screening, risk assessment, connections to resources after discharge and aftercare, while changing ED staff attitudes and increasing knowledge about suicide.

ED SUICIDE PREVENTION: RESOURCES

Is Your Patient Suicidal? Poster and Companion Resources*:* Developed by the SPRC, these resources provide ED professionals with information on recognizing and responding to acute suicide risk. A recent ED-based intervention found that exposure to these resources increased the likelihood that ED staff will ask patients or family members about suicidal ideation.

Safety Planning Guide: A Quick Guide for Clinicians: Developed by the Department of Veteran Affairs, this guide for clinicians may be used to develop a safety plan, which is a prioritized written list of coping strategies and sources of support to be used by patients who have been deemed to be at high risk for suicide.

After an Attempt: A Guide for Medical Providers in the ED Taking Care of Suicide Attempt Survivors; *A Guide for Taking Care of your Family Member After Treatment in the ED;* and *A Guide for Taking Care of Yourself After Your Treatment in the ED*. Developed by the National Suicide Prevention Lifeline, these series of pamphlets inform physicians, family members and suicide attempt survivors on important issues relating to suicide attempt, what to expect in the ED and aftercare for the suicide attempt survivor.

ED SUICIDE PREVENTION: PROMISING PRACTICES

ED Means Restriction Education: This intervention is for adult caregivers of youth (6-19 years) who are seen in an ED and determined through a mental health assessment to be at risk for committing suicide. It is designed to help adult caregivers of at-risk youth recognize the importance of taking immediate action to restrict access to lethal means in the home.

ED Intervention for Adolescent Females: Developed by UCLA, this program is for girls ages 12-18 who are admitted to the ED after attempting suicide. This intervention aims to increase attendance in outpatient treatment following discharge from the ED to reduce future suicide attempts.

LOCAL ACHIEVEMENTS

The Effort's Suicide Prevention & Crisis Services: This Sacramento County-based crisis center has an ED Follow Up program in place with local EDs to provide 30 days of phone follow up support to individuals seen in the ED for current suicidality or suicide attempt. Many ED staff have been trained on risk assessment and responding to suicide in the ED. This program has been extremely effective in preventing suicide deaths, re-attempts, and readmissions post discharge. Many successful linkages have been made to follow up care, as well. For more information, please contact Liseanne Wick (lwick@theeffort.org).

Didi Hirsch Community Mental Health Center: This Los Angeles-based accredited crisis center has a SAMHSA-funded pilot program with Cedars-Sinai Hospital to provide follow-up to individuals who are discharged from the ED following a suicide attempt or suicidal ideation. In addition, they are providing suicide prevention training to ED staff. For more information, please contact Shari Sinwelski (ssinwelski@didihirsch.org).

ANNOUNCEMENTS & BREAKING NEWS

California Department of Public Health EPICenter. The California Department of Public Health recently upgraded their data website, EpiCenter**.** Users can create custom tables on suicides, as well as self-inflicted injuries treated in hospitals and emergency departments. Users can also search data from the California Violent Death Reporting System Project.

Center for Disease Control and Prevention (CDC) Self-Directed Violence Surveillance. This recently released document is intended for use by individuals and organizations interested in gathering surveillance data on self-directed violence and to help promote and improve the consistency of data.

Recommendations for Media Reporting on Suicide. Developed by the American Foundation for Suicide Prevention, SAMHSA and the Suicide Awareness Voices of Education, this document provides concise, practical suggestions for journalists in safe reporting about suicide and about informing the public about suicide as a national health problem. Visit www.ReportingOnSuicide.org for more information.

REFERENCES ON SUICIDE PREVENTION IN EDS

Larkin GL, Smith RP, Beautrais A (2008). Trends in US Emergency Department Visits for Suicide Attempts, 1992-20001. ***Crisis 29(2): 73-80.*** This study provides a breakdown of trends by age, gender, ethnicity and geography with regards to ED visits for suicide attempts.

Larkin GL, Beautrais A (2010). Emergency Departments Are Underutilized Sites for Suicide Prevention. ***Crisis 31(1): 1-6.*** This editorial provides an overview of why EDs are an appropriate site for suicide screening and intervention and how EDs can improve their practices.

King CA, et al. (2009). Adolescent Suicide Risk Screening in the Emergency Department. ***Society for Academic Emergency Medicine 16(11): 1234-1241.*** This cross-sectional study examined the concurrent validity and utility of an adolescent suicide risk screening tool for use in EDs and the prevalence of positive screens for adolescent males and females using two different set of screening criteria.

Knesper DJ, American Association of Suicidology, & Suicide Prevention Resource Center (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. ***Newton, MA: Education Development, Inc.*** This report provides an extensive review and analysis of current literature on ED suicide prevention and provides recommendations for both practice and future research.

Cerel J, et al. (2006). Consumer and family experiences in the emergency department following a suicide attempt. ***Journal of Psychiatric Practice. 12(6): 341-347.*** This survey-based study found that more than half of ED patients and a third of family members felt directly punished or stigmatized by ED staff following a patient's suicide attempt.

SoRelle R (2011). EDs Struggle to Cope with Suicidal Patients. ***Emergency Medicine News. 33(3): 24-25.*** This narrative provides a glimpse into the issues that ED physicians face when treating suicidal patients.